

POLST Offers Next Stage in Honoring Patient Preferences

Diane E. Meier, M.D. and Larry Beresford

NATIONAL ADVOCACY GROUPS have spent considerable effort promoting advance care planning and encouraging completion of advance directives in order to enhance congruence between the kind of medical care people say they would want to receive during serious or terminal illness and the care they typically receive. These efforts continue despite a growing body of evidence suggesting that conventional advance directives have not been as helpful as proponents hoped.¹

A new and rapidly diffusing approach to ensuring care concordant with patient preferences, executed closer to the time of need, is called the Physician Orders for Life-Sustaining Treatment or POLST. POLST translates patient preferences into specific medical orders to be honored by physicians and other health care workers during a medical crisis. POLST advocates emphasize that this approach, first developed in Oregon in 1991 and recently adopted statewide in California and New York, is not an advance directive but rather is a set of medical orders. An advance directive is a legal document, such as living will or durable power of attorney for health care decisions, which is completed far in advance to inform a potential future medical circumstance in which the individual may be incapable of making decisions or expressing preferences for care.

POLST, by contrast, is a medical order signed by a physician, after consultation with the patient or—if the patient lacks capacity—with the patient's legal surrogate. POLST is appropriate for people who already have an advanced chronic illness, for whom the prognosis is measured in 1 to 2 years. It specifically addresses medical decisions and options that are likely to arise in the near future, including cardiopulmonary resuscitation, antibiotics for infections, artificial food and fluids, and whether or not the patient would want to be rehospitalized. More relevant and specific than conventional advance directives, POLST provides explicit guidance to health professionals under predictable future circumstances (such as development of pneumonia in a patient with advanced dementia). (See Fig. 1 for an illustration of a POLST form.)

The Center for Ethics in Health Care at Oregon Health & Sciences University (OHSU) describes POLST as a new paradigm for the health care system. The center established the

National POLST Paradigm Initiative Task Force (see www.polst.org) to facilitate the development, implementation, and evaluation of POLST initiatives nationwide. Subsequent to the Oregon initiative, a number of states have implemented POLST programs, either statewide (Idaho, New York, North Carolina, Washington, and West Virginia) or as regional or community projects. Others are exploring POLST coalition building, dissemination and implementation, with consultation, facilitator training and technical assistance from OHSU. (See Fig. 2 for a map showing participating states.)

The basic POLST approach provides actionable information on how to honor the wishes of a patient with a life-threatening condition regarding a range of available medical treatments; documents those wishes in a physician-signed medical order on a brightly colored (typically pink) form that accompanies the patient across and between settings of care, including ambulance rides; and formalizes agreement by health professionals across all settings in the community to honor medical orders contained in the POLST form.

Experts emphasize that POLST is not just a glorified do-not-resuscitate (DNR) order. Patients with POLST may indicate their desire either for or against specific life-sustaining treatments, and may endorse different combinations of relevant treatments. According to one study in Oregon, a majority of patients requesting DNR via POLST actually wanted potentially life-prolonging interventions in at least one other treatment category. (For example, a nursing home patient's POLST might specify no rehospitalization and no cardiopulmonary resuscitation [CPR], but request antibiotics in case of infection, and tube feeding for nutrition and hydration.) Through its specificity and provision of yes-or-no answers for each of the common decision points (hospitalization, CPR, intensive care, ventilatory support, artificial nutrition and hydration) POLST provides quick and clear guidance to any health professional who simply reads the single-page form. Patients may also revoke an old POLST form and write a new one as their disease and other circumstances change.

When combined with state policies and/or legislation recognizing the document as a valid medical order and broad-based education for health care professionals on how it works, POLST can convert patient preferences into immediately actionable medical orders that are readily accessible to medical

Diane E. Meier, M.D., FACP, is director of the Center to Advance Palliative Care at Mount Sinai School of Medicine, director of The Lillian and Benjamin Hertzberg Palliative Care Institute, Professor of Geriatrics and Internal Medicine at Mount Sinai School of Medicine, and Catherine Gaisman Professor of Medical Ethics at Mount Sinai School of Medicine in New York City.

Larry Beresford is a freelance health care journalist based in Oakland, California, and a consultant to the Center to Advance Palliative Care.

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician, NP, or PA. These medical orders are based on the person's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.

| | | |
|----------------------------------|---|---|
| Last Name/ First/ Middle Initial | | |
| Address | | |
| City / State / Zip | | |
| Date of Birth (mm/dd/yyyy) | Last 4 SSN | Gender |
| ____/____/____ | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> M <input type="checkbox"/> F |

A **CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.**
 Check One Attempt Resuscitation/CPR Do Not Attempt Resuscitation/DNR (Allow Natural Death)
 When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

B **MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.**
 Check One **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.**

Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer to hospital if indicated. Avoid intensive care.**

Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Includes intensive care.**

Additional Orders: _____

C **ANTIBIOTICS**
 Check One No antibiotics. Use other measures to relieve symptoms.
 Determine use or limitation of antibiotics when infection occurs.
 Use antibiotics if medically indicated.

Additional Orders: _____

D **ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.**
 Check One No artificial nutrition by tube.
 Defined trial period of artificial nutrition by tube.
 Long-term artificial nutrition by tube.

Additional Orders: _____

E **REASON FOR ORDERS AND SIGNATURES**

My signature below indicates to the best of my knowledge that these orders are consistent with the person's current medical condition and preferences as indicated by the **discussion with:**

Patient Health Care Representative Parent of Minor

Court-Appointed Guardian Other _____

| | |
|---|-----------------|
| Print Primary Care Professional Name | Office Use Only |
| Print Signing Physician / NP / PA Name and Phone Number () | |
| Physician / NP / PA Signature (mandatory) Date | |

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

FIG. 1. Physician Orders for Life-Sustaining Treatment (POLST). Pictured above is the front page of the POLST form currently used in Oregon, showing medical orders regarding various choices in life-sustaining treatments. Page two of this document includes elements such as patient/legal representative signature, contact information of the surrogate, health care professional preparing the form, supervising physician phone number, and instructions for health care professionals. Source: Center for Ethics in Health Care, Oregon Health & Sciences University, Portland, Oregon.

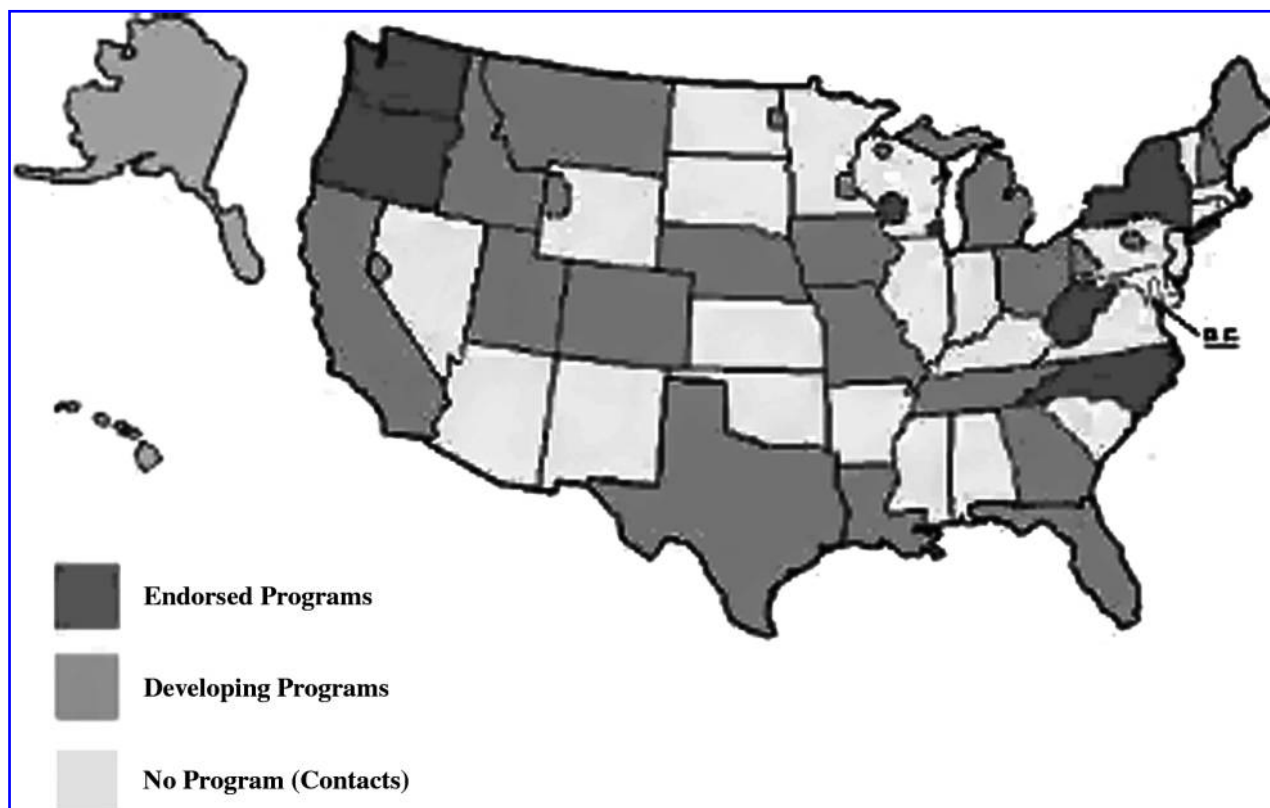


FIG. 2. Physician Orders for Life-Sustaining Treatment (POLST) state programs. This map shows the various states and localities that have POLST programs either endorsed by the National POLST Paradigm Initiative Task Force (shown in dark shading) for meeting specific criteria (see www.ohsu.edu/ethics/polst/developing/core-requirements.htm for criteria); or under development (light shading), which have submitted their program information to the task force, as of January 2009. Blank areas have no listed POLST program contacts. *Source:* Center for Ethics in Health Care, Oregon Health & Sciences University, Portland, Oregon.

personnel, including emergency medical technicians (EMTs). Health professionals in the hospital may encounter patients who bring POLST orders with them. Patients likely to be in their last 1 to 2 years of life should be helped to complete a POLST form prior to hospital discharge.

POLST Comes to California and New York

On August 4, 2008, California Governor Arnold Schwarzenegger signed AB 3000, making POLST statewide effective January 1, 2009, after a year of pilot testing by eight local POLST initiatives. The legislation catalyzed POLST dissemination across the state, notes Judy Citko, executive director of the California Coalition for Compassionate Care (CCCC), which has spearheaded local and statewide POLST efforts with financial support from the California HealthCare Foundation. "We felt it was best to start at the local level with community coalitions involving EMS, hospitals and nursing homes. Those three partners are especially critical," she explains.

"The new law requires health care professionals to honor POLST," Citko says. "If it looks valid on its face and you honor it, you will be operating within community standards of practice and won't face liability." However, achieving the aims of POLST requires more than just passing legislation. A statewide POLST Task Force is developing standardized

training materials and model policies and procedures for operationalizing POLST, "with basic, tangible instructions for how to have what can be a fairly sophisticated conversation," Citko says. Seventeen community agencies have also received grants to establish POLST as a community standard-of-practice.

New York's version is called MOLST, or Medical Orders for Life-Sustaining Treatment. Adapted from Oregon's POLST, New York's initiative was one of several projects developed and implemented by the Community-wide End-of-life/Palliative Care Initiative, a health care and community collaborative. MOLST began as a volunteer program in health care facilities in 2003, and then in 2005 it was approved by the state Department of Health for use in all health care facilities in Monroe and Onondaga Counties. On July 9, 2008, Governor David A. Paterson signed legislation expanding the program statewide, permanent and recognized in the community. For more information on New York's efforts, see www.CompassionandSupport.org.

"I'm continuing to advocate for community conversations, engaging adults in conversations about their future care, and promoting greater penetration for advance directives in our community. We advocate for choosing the right health care agent, for clarifying values, for having these conversations at the kitchen table," says Patricia Bomba, M.D., vice president and medical director of geriatrics for Excellus Blue-Cross BlueShield, who led the initiative as well as advocacy

for the state bill. "But for individuals with existing, serious, life-limiting illnesses, MOLST focuses the conversation on goals of care and aligns it with the reality of the patient's condition and prognosis."

MOLST and POLST do not replace advance directives, Bomba says, but are for a more targeted population, one that is nearing the end of life. "MOLST is important to initiate in hospitals, nursing homes and the community, with the goal of having the conversation earlier, before the person ends up in the ICU receiving care they would not have wanted. MOLST also travels through the system with the patient. It is premised on effective communication and transfer of the patient's wishes and the promise by health care professionals to honor those wishes, based on a proven model. Early adopters have tended to be the same facilities that have embraced palliative care."

How Does Palliative Care Interface with POLST?

Most palliative care professionals would say that a major—if not the largest—part of their work is helping patients clarify values and treatment preferences in the face of advancing illness and prognosis and in light of realistic options for care. This process of goal clarification requires intense, time-consuming, face-to-face conversations with patients and/or family members—sometimes in large family meetings. The process of completing a POLST form is also a values clarification process, but one that results in specific and explicit medical orders to ensure that treatments received are actually concordant with the patient's goals for care.

Palliative care teams and other health professionals should ascertain if there is a valid and accessible advance directive or completed POLST form for a given patient and then review and, if necessary, update the contents with the patient, if competent, or the legal surrogate. In planning for the patient's future care and eventual discharge from the hospital, the palliative care team should routinely update the advance directive or POLST order, or complete a new one if necessary.

Palliative care teams have strong incentives to seek out or complete the POLST process with their patients. A preexisting document suggests that some kind of values conversation with health professionals and/or loved ones has already taken place, providing a foundation for a specific conversation relevant to the current medical circumstance. The POLST form can also provide a checklist or script for addressing common treatment issues and choices, especially if time is short.

Sending the patient home with a completed or updated POLST form may improve the odds that care plans painstakingly developed in the hospital will actually be honored after the patient leaves. A major source of frustration for hospital palliative care teams is seeing careful planning evaporate shortly after discharge because of lack of continuity of care in the community, often resulting in repeated and preventable rehospitalizations.²

According to research following OHSU patients post-discharge who had received palliative care consultations in the medical center,³ only 10% of those patients were readmitted to the hospital within 30 days, and only 5% of those discharged alive ultimately died in the hospital. The study did not break out patients discharged with or without POLST, but in Oregon it has been standard practice for patients discharged following a palliative care consultation to have a POLST form.

Palliative care practitioners are leaders and facilitators of cultural change, and thus can play leadership roles in advancing POLST concepts both within their facilities and as part of community coalitions attempting to implement a POLST initiative, says Patricia Bomba. "The palliative care team can utilize this process, recognizing that much of what it already does is clarifying goals of care—but then turn that conversation into a portable medical order. This ensures that the hours they have put in with the patient will have impact and travel beyond the hospital's walls."

"The way POLST helps palliative care professionals is by creating a system to operationalize what they already do," Judy Citko adds. "There's nothing magic about a particular form. But you are bringing the attention of the whole system to advance care planning," she says. Goals clarification is most effective if it informs medical decision-making and experiences across the continuum of the health care system.

"Palliative care professionals are passionate about these issues and the need to change the system. POLST initiatives are a powerful social change tool to help diffuse the palliative care innovation beyond the walls of the hospital. We find a lot of palliative care people understand the need, but how do you bring about change? You need local champions, who can bring in partners and form coalitions to work on multiple levels simultaneously," Citko says. A first step might be to review the POLST website (www.polst.org) to see if there are local and regional colleagues interested in working on a POLST project.

Contributions to Quality

Susan Tolle, M.D., and Patrick Dunn, M.D., are faculty at OHSU's Center for Ethics in Health Care and have provided support to those who wish to spread Oregon's POLST Paradigm to other states. "Our message for the palliative care community is that you can do this," Tolle says. If there is a POLST-type system in the state or locality, then it would make sense for a majority of hospitalized palliative care patients to be discharged with a POLST order in place. If not, palliative care professionals can be agents for changing the system.

"It may be hard to achieve legislative change or a statewide program. But it's not so hard to get your hospital's electronic medical record to clearly show whether a patient has a valid advance directive or POLST-type medical order," she notes. "Some hospitals do not have a good system for keeping track and assuring rapid retrieval of these documents. But you can work with information technology staff to make it easier to find the form and with the hospital's administration to get a policy implemented that these medical orders will be respected," Tolle says. "If a patient receives resuscitation in the hospital when it is clearly documented that they didn't want it, that should be considered a sentinel event, a serious medical error."

Palliative care teams can help to educate the rest of the system, bringing hospitalists along and teaching them to use POLST as a routine physician role in care of seriously ill hospitalized patients, Dunn adds. "There is also the community linkage and policy piece for palliative care—our connection with the broader healthcare system and involvement in sound policy development, how we work to modify the electronic medical record, and leadership in community education—both professional and lay."

The POLST Paradigm also offers important opportunities for quality initiatives, reflected in its endorsement by the National Quality Forum and other national quality advocates.⁴ For the individual hospital, what proportion of patients are discharged with POLST, and what proportion of those orders get honored? Ultimately, Tolle suggests, an established POLST system can help to reduce unwanted hospital deaths—as has happened in Oregon, which has one of the country's lowest in-hospital death rates.

How Do Palliative Care Practitioners View POLST?

"I think it's easy and it's clear. With a bright pink form, it's easy to remind people that it goes wherever the patient goes," says Joanne Hatchett, R.N., M.S.N., F.N.P., palliative care coordinator for Woodland Healthcare in Woodland, California. Hatchett, who works across settings from hospital to nursing home to home, and her internal medicine colleague, Jeff Yee, M.D., helped to implement one of California's local POLST pilot projects.

"POLST, unlike advance directives, has a degree of specificity that helps us define clear critical situations that really happen to people. We can talk to patients about ventilator care, which is a very different decision than cardiac resuscitation," Yee says. Given that palliative care teams are accustomed to talking about these issues, does POLST still make a contribution to their work? "I think the answer is yes," Yee responds. "It further forces the discussion in the community—and on the palliative care team—about these very specific and predictable treatment decisions."

Thomas Caprio, M.D., is a geriatrician in Rochester, New York, program director for a nursing home-based geriatric fellowship, and associate medical director for a local hospice. "I've been able to see MOLST at work in different settings—particularly for transitions of care across settings, which are the times of greatest vulnerability for geriatric patients," he observes. "It is hugely beneficial that MOLST is actionable when moving across settings. It also takes us beyond simple documentation of DNR, capturing more subtle nuances related to levels of care and goals of care. The form gives a framework for a longer conversation about new symptoms and diagnoses affecting goals and directives. But it's not just a document or a form—MOLST represents a transformation in the community and in medical practice."

However, Dan Johnson, M.D., director of the Life Quality Institute in Denver and regional department chief of palliative care for Kaiser Permanente in Aurora, Colorado, wonders if there is a risk that health professionals might become dependent on POLST. Patients' opinions about medical treatment can be very fluid and changeable, he observes. "Regardless of what they said weeks or months ago, we still have a responsibility to make sure that the same values are driving their treatment preferences today."

Although POLST orders are reviewed and can be changed whenever there are changes in a patient's values or medical condition, Johnson wonders if a completed POLST form might start to supplant the serious, time-consuming, and emotionally complex conversations about current values and preferences that are the heart of the palliative care encounter. "The danger is that if the palliative care team gets sloppy in the face of caseload pressures, it might rely on what's in POLST and skip over or shortchange the essential need to revisit patient values and preferences today," he says.

The advantage of POLST is that it answers a lot of questions and makes a lot of things clear, Johnson says. "It helps in a time of crisis and chaotic transition. The advantages seem obvious. But if we don't use it as a springboard for further conversations, we can get into trouble. If other health professionals view POLST as palliative care, or if hospital administrators say we don't need a palliative care team because we have POLST, that would be a step backward."

Form Can Drive Conversation

David Kessler, R.N., vice president of patient support care services for Citrus Valley Health Partners, a three-hospital system in Los Angeles County, California, offers a personal encounter with POLST. "My stepmother recently suffered a stroke, and I had a conversation with nursing facility staff about her treatment. As a palliative care professional, I was really impressed. I thought they asked great questions about what my stepmother would have wanted," he relates.

Later, they called Kessler and asked him to come back to the facility to sign some paperwork. "They pulled out a completed POLST form, which they had filled in based on our conversation. I loved it that they had turned POLST into such a helpful conversation," he relates. "Advance directives are still a hard sell in our community, because it means making plans for an unknown future. But when I talk to EMTs and other health professionals about POLST, they say, 'It makes our lives easier—when we know patients' wishes, that's 90% of the battle.'"

References

1. Perkins HS: Controlling death: The false promise of advance directives. *Ann Intern Med* 2007;147:51–57.
2. Meier D, Beresford L: Palliative care's challenge: Facilitating transitions of care. *J Palliat Med* 2008;11:416–421.
3. Fromme E, Bascom P, Smith MD, Tolle S, Hanson L, Hickam D, Osborne M: Survival, mortality, and location of death for patients seen by a hospital-based palliative care team. *J Palliat Med* 2006;9:903–911.
4. National Quality Forum: A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report, 2006, p. 43.

